Palmer Homecare Services
SERVING NORTHEAST IOWA

Home Health
Home Medical Equipment
Heart of Iowa Hospice
Community Health

STATEMENT BY

JULIE WEIDEMANN CRT, RCP, BS

DIRECTOR, PALMER HOME MEDICAL SUPPLY

HEARING ON DMEPOS COMPETITIVE BIDDING PROGRAM

BEFORE THE

HOUSE SMALL BUSINESS SUBCOMMITTEE

ON

RURAL AND URBAN ENTREPRENEURSHIP

UNITED STATES HOUSE OF REPRESENTATIVES

May 21, 2008

Main Office: 200 Jefferson St.
West Union, IA 52175
563-422-6267 or 1-800-335-0711
Fax: 563-422-9875

Branch Offices:
1602 South Frederick
Oelwein, IA 50662
319-283-4489
Fax: 319-283-1384

909 West 1st St.
Sumner, IA 50674
563-578-5055
Fax: 563-578-5204

INTRODUCTION

Chairman Shuler, Ranking Member Fortenberry, and Members of the Committee, I am Julie Weidemann, Director of Palmer Home Medical Supply. I am pleased to come before this Sub-committee to discuss with you the profound risks of the DMEPOS Competitive Bidding (CB) Program being implemented by the U.S. Department of Health and Human Services.

I am a Certified Respiratory Therapist and an Iowa Licensed Respiratory Care Practitioner. I have worked in the home medical equipment industry since 1988. I started my homecare career as a respiratory therapist and, in 1994, created and instituted Palmer Home Medical Supply, a department of Palmer Lutheran Health Center, Inc., which is a 25-bed hospital in West Union, IA. I returned to college and obtained a business management degree from Upper Iowa University in 2003.

My company, Palmer Home Medical Supply, serves ten counties in rural northeast Iowa, covering 2,500 square miles, close to 50% of my business includes Medicare beneficiaries. We have three locations in West Union, Oelwein, and Sumner. As Director, I oversee a staff of ten employees: three respiratory therapists, one registered nurse, two medical equipment delivery technicians and four customer service/billing staff. According to a study on women-owned businesses conducted by the U.S. Small Business Administration, between 1997 and 2002, the numbers of women-owned firms increased by 19.8 percent and of the number of women-owned employer firms, increased by 8.3 percent. Also, firms owned by women increased employment by 70,000 individuals.[1] Women-owned businesses are a critical part of today's economy and I am concerned that the competitive bidding program will force many of these companies out of business.

Currently, I serve as Vice-President and the Education Committee Chair for the Midwest Association for Medical Equipment Services (MAMES). I am also a member of VGM & Associates of Waterloo, Iowa. I am active regarding legislative issues in the home medical equipment industry and I am very passionate about ensuring the patients I serve receive quality care. I assisted in the creation and implementation of the compliance program for the hospital, and I continue to serve as the Co-Compliance Officer for Palmer Lutheran Health Center. I also oversee all mandatory accreditation activities for Palmer Home Medical Supply.

Concerns with DMEPOS Competitive Bidding Program

In Section 302 of the Medicare Modernization Act (MMA) of 2003, Congress mandated the Centers for Medicare and Medicaid Services (CMS) to include small business protections, however, CMS could not have damaged small home medical equipment (HME) business more if they had tried to do so. The results of the competition are unambiguous proof that CMS not only failed to protect small business but, if not stopped, CMS will decimate the ranks of small HME businesses in a matter of months. At the start of this process it was widely estimated that the HME business sector

[1] *Women in Business, 2006 A Demographic Review of Women's Business Ownership*. Ying Lowrey, Office of Economic Research, Office of Advocacy, U.S. Small Business Administration. August 2006, No. 280.

consisted of over 85% of small business units. CMS created a target set-aside of 30 percent for small businesses. CMS then removed the viability of the only economy of scale available to small businesses that wanted to continue to participate, as demonstrated in the consolidated billing network model, by artificially cutting nearly in half the definition of a small business and prohibiting consolidated billing.

This is a fatally-flawed program and no amount of rearranging the deck chairs will save this Titanic-like scheme, which at its heart, contains an unavoidable downward spiral of desperate bids. As a result, there will be less and less quality in service and products until the bottom is reached and we are left with near-bankrupt providers. The current existing solid core of high-quality and great-service small business providers will be gone and the elderly and disabled will be worse off because of it.

At the top of the CMS rhetoric on this issue is the question of price. The statistic of 26% savings to the program is misleading. Medicare beneficiaries, in part, select their providers for the products, but even more so, for the quality of care and service. Competitive bidding takes this choice away from the beneficiary at a great cost. Please do not move forward with a flawed program that destroys small businesses and takes services away from our patients for the reason of saving money for the program. I do believe that if CMS increased its work in policing the fraudulent providers and banning them from the Medicare program, the cost savings would be substantial. This then allows the small HME business providers to do what we do best - take care of our patients with compassion and great service.

Impact of DMEPOS Competitive Bidding on Rural Providers

Where Palmer Home Medical Supply would have the largest concern over competitive bidding program would be in the MMA 2003 provision that includes the ability of CMS to apply payment rates achieved through bidding to non-bid areas (known as inherent reasonableness authority) to the fee schedule in 2009. This provision allows CMS to take the "savings" that is achieved in desperation bids from Round One and apply pricing nationwide with a new fee schedule. CMS has stated on several occasions that "Competitive Bidding will generate a robust selection even if it doesn't result in substantial cost savings". This implies that CMS feels that it will have detailed information on what bidders in the first 10 competitively bid areas (CBAs) are willing to charge and, by implication, how low they can go and still stay in business. **CMS could and will use the data to impose an inherent-reasonableness standard on the entire industry. This will adversely affect rural providers nationwide.**

How will inherent reasonableness affect rural providers?

- The bidding process is effectively a closed auction subject to providers "gaming" the system.

• The rational view holds that individual bidders will logically adjust their bids to reflect their own company and market evaluation and expectations, but logic does not necessarily apply to the competitive bidding program - and this fact muddles the strategies of even the savviest HME bidding companies.

As we review the results of Round One we see that there were four different types of providers:

1. Speculative bidders who had no idea what their actual costs were and simply bid to win.
2. Indifferent bidders who bid with the intent to sell their business. These bidders bid below their cost with the idea or hope that the median bid would pull up their bid - but again bid only to win without consideration of the impact on pricing.
3. Bidders were concerned for their businesses and beneficiaries and had looked at their true costs, bid a realistic figure and lost the bid.
4. Bidders who similarly were concerned for their businesses and beneficiaries and bid, but fell under the pivotal bid and "won" the "winners curse". They bid a realistic figure but the median bid pulled them below what they can effectively afford to stay in business. They were forced then to accept a bid offer that they know will put them out of business.

A review of Round One proves this point:

(CMS reported this information to staff who attended an April 22 CMS briefing for congressional staff.)

- 6,358 bids were submitted.
- 1,005 separate and unique bidding numbers or an average of six bids per company. (Note: Due to several network-bidding entities, the number of unique bidding companies is estimated at 1,100 – 1,200.)
- 630 bidding entities were disqualified from the process due to various reasons; the majority for missing information from the applications. These bids were never considered within the pricing methodology. Of these, 283 were within the range "to win".
- 318 bidders were offered contracts.
- 316 returned a signed contract.
- Only about 5% of the eligible small providers were offered a contract, and about 16% of large providers.
- A total of 1,254 contracts were accepted.

Why were CMS' estimates in the Final Rule on competitive bidding so overstated? Does it really matter that 64% of the suppliers who were offered contracts were small suppliers when the total number of contracts offered (1,335) was only 14 % of what CMS had originally forecast they would offer in the Final Rule (9,584)? In the Final Rule CMS estimated that 60% of the bids would be awarded contracts. CMS received over 6,000 separate bids and only 1,335 were offered contracts (22.5%). What happened? Because of this failed system are rural providers now told they will

need to budget for a 26% cut based on the implementation of the inherent reasonableness provision? CMS has not shared bidding data or the criteria that they used to establish new Medicare payment rates or the criteria by which suppliers were evaluated. I question how CMS made their decisions on providers' financial viability and business expertise and am concerned that the inefficient manner in which the program was implemented threatens the integrity of the entire program.

Impact of DMEPOS Competitive Bidding on Beneficiaries

Eliminate Patient Choice:
Competitive bidding will simply limit choice for beneficiaries.

Currently Medicare beneficiaries have their choice of equipment suppliers. They base this choice upon the quality of service and the quality and appropriateness of the equipment provided to them. By its very nature, competitive bidding will significantly reduce the number of suppliers available to serve the beneficiary. Although proposals for national competitive bidding call for the establishment of quality standards, beneficiaries prefer the ability to choose from a wide range of providers to ensure quality, just as they do among physicians. Relying on government-defined and government-enforced standards is no substitute for the ability to move to another provider. That is why more than twenty organizations in the Consortium for Citizens with Disabilities Health Task Force have urged Congress to oppose national competitive bidding.

Reduced Service:
Competitive bidding will limit access to high quality, medically necessary products and services. When price becomes the primary determining factor for eligibility to serve Medicare beneficiaries, suppliers are under tremendous pressures to submit low bids by reducing or eliminating high quality product lines or more intensive beneficiary services. Medicare is the dominant purchaser of these goods and services, and few companies can survive without the ability to serve Medicare beneficiaries. Although the proposal contends that standards can protect quality, the government's ability to develop and enforce standards is untested. Further, standards are not a substitute for choice.

Curtailed Innovation:
Competitive bidding will stifle medical innovation.

Suppliers will be unwilling to base their bids on new medical technology and services, which often cost more than standard equipment and services but are more effective and have a greater positive impact on quality of life. If providers select lower cost items, this will have a rippling effect throughout the marketplace. Consequently, manufacturers will have no incentive to develop new technologies that improve outcomes or quality of life if the technologies raise up-front costs.

Threat to Small Businesses:
Competitive Bidding will eliminate small businesses.

The competitive bidding process awards contracts only to those suppliers that are able to offer a qualifying price. Consequently, many businesses will be excluded from the marketplace. Further, those small businesses that do win awards will face great difficulty in conducting business at reduced reimbursement rates and competing with large companies that have economies of scale. Indeed, in Polk County (one of the competitive bidding program demonstration sites from 1999-2001) after only two rounds of bidding, one national company emerged as the dominant provider in the Medicare oxygen market. The national company did not bid but acquired companies who won bids.

Monopoly / Expanded Government:
Competitive bidding will create a huge national bureaucracy at CMS and probably provide little savings. The National Business Services, Inc. (NBS) released a study that shows that the national competitive bidding program includes fifty separate legislative mandates or directives. According to NBS, the mandates will increase the CMS bureaucracy by over sixteen hundred personnel, or over one-third of its current size. In addition, a review of the Congressional Budget Office's (CBO) budget estimates for the national competitive bidding program by PricewaterhouseCoopers indicates that savings may not be substantial. Indeed, there is great uncertainty in the CBO's projections of $7.7 billion in savings over 10 years. According to PricewaterhouseCoopers reasonable assumptions, the entire program would save only a billion dollars over the same ten-year period.

Impact Competitive Bidding Will Have on the Beneficiary and the Transfer of Ownership of Oxygen Cylinders

Almost 224,000 Medicare beneficiaries who currently rely on home oxygen therapy may experience a disruption of their service if their provider does not grandfather, and tens of thousands of new patients prescribed the therapy will have severely limited access from July 1, 2008 forward. As they assume ownership of their equipment in January 2009, they may have to switch providers in order to obtain portable oxygen.

It is **neither safe nor fair to shift the burden of cost for maintenance and repair for medical equipment to disabled or elderly Medicare beneficiaries**. If the equipment is purchased, the patient incurs additional fees for clinical or emergency support or for exchange of malfunctioning equipment.

Oxygen is a Prescription Drug: Unregulated Use Poses Dangers and Burdens for Seniors

Medical oxygen can only be prescribed by a physician specifically for individual patient use. Oxygen is a drug and can be dangerous if not administered or used properly.

The use of medical oxygen equipment is imperative to the overall well-being of patients on oxygen therapy. Homecare companies currently provide 24-hour, emergency on-call service to assist patients with trouble-shooting equipment problems, improper use, or equipment failures.
The new rent-to-purchase payment policy for home oxygen equipment enacted in the Deficit Reduction Act (DRA) requires that after a 36-month rental period, title and responsibility for maintenance and service for all home oxygen stationary and portable technologies would be transferred to the Medicare beneficiary. The President's proposed 2007 budget would worsen the policy by forcing transfer of ownership and responsibility after 13 months.

With the transfer of ownership of the medical device to the patient, the control over the dosage levels shifts to the patient increasing the risk of self-medication to the patient's own detriment. This is an unreasonable burden and worry for seniors, especially on top of navigating Part D drug benefits. Just last week, one of my respiratory therapists was in a Salvation Army Store in Cedar Rapids, IA, and sitting there was an oxygen concentrator and three oxygen cylinders for sale - no doctor order required. As already stated, oxygen is a drug that must be prescribed by a physician, and when beneficiaries start owning this equipment, where will it go when they no longer need it? Obviously, for sale at a Salvation Army, maybe a local garage sale, the Internet...as a respiratory therapist this worries me to no end. Oxygen, when used inappropriately and without proper training, has very dangerous consequences that could result in death from underdosing or overdosing, or a deadly fire due to lack of training of the safe use and storage of oxygen. Providers currently educate each patient and their caregivers on these very critical issues.

Costs Related to Home Oxygen Therapy
Like many other medical therapies performed in conjunction with medical devices, the equipment cost is only a small fraction of the overall cost associated with the provision of home oxygen therapy.

What else do providers do?

- Provide 24-hour support for our patients. (This means I pay an employee to be on call after hours, weekends and holidays, and pay overtime and mileage when they do get called for a service call.)

- If a patient is having a problem, day or night, we help them troubleshoot the problem over the phone. If that is unsuccessful, we go to their home. We have traveled 90 miles round-trip to help a patient screw on a water bottle humidifier to their oxygen machine because they couldn't get the threads lined up correctly due to their arthritis, and no other caregiver was available.

- We brave the Iowa winters of snow and ice to get oxygen cylinders to clients due to an extended power failure, as their oxygen machine requires electricity to operate. The back-up oxygen cylinder system I place in every home of an oxygen user, at no charge to them or Medicare, lasted the patient 14 hours, but the power was out for several days.

• We provide professional respiratory therapists and nurses to visit our oxygen patients every 1-3 months to ensure the equipment is working properly and that they are using their oxygen as prescribed by their physician. We give them new supplies and change their tubing, we check their heart rate, blood pressure, oxygen level, listen to their lungs - all to determine their current condition. Any alarming findings are reported to their physician so that appropriate interventions can be made to prevent a hospitalization.

• We deliver tanks to our patient's home or meet them at the office on a Sunday morning because they want to go to church, and they forgot to call us and tell us their tanks were empty last Wednesday.

This is the short list, but I will stop here. Who is going to do all of this when patients own their equipment? I cannot provide these services for free, and not many of my fixed-income Medicare patients can afford to pay me extra out of their social security check for these services. So it will simply not get done. Patients will be hospitalized more often, and the Medicare program is going to see a rise in hospital expenditures much greater than the decline in the DME expenditures.

While there is broad language in DRA regarding "payments for oxygen" (the oxygen itself) and "maintenance and service" after the title transfer of the equipment, there are no specifics or assurances regarding availability of 24-hour emergency service and other services, supplies, and emergency back up required by home oxygen patients suffering from respiratory diseases such as COPD. In the Medicare system today there are no codes or policies governing the maintenance and services for oxygen technologies. The DRA provides no guidance for the myriad service components currently required and incorporated into the Medicare oxygen rules and payment, including all patient training, deliveries, disposable accessories, billing, clinical professional support, 24-hour emergency service and equipment replacement.

Nearly One Million Medicare Beneficiaries Receive Oxygen Therapy

Oxygen equipment is critical to approximately one million Medicare beneficiaries who suffer from respiratory illnesses such as chronic obstructive pulmonary disease (COPD) and who require oxygen therapy for their long-term survival. Approximately 15 million Americans have been diagnosed with COPD. An estimated 15 million more have undiagnosed COPD.

Home Oxygen Therapy is both Clinically Effective and Cost-Effective

Oxygen is the only current treatment or drug scientifically proven to extend the life of patients with chronic lung disease.

In 2002, there were 673,000 hospitalizations for COPD. Their average length of stay was 5.2 days. The average Medicare cost for one day in the hospital is $3,606, and the average admission for COPD therefore costs more than $18,000.

In contrast, the current average annual cost for home oxygen therapy is $2,784, less than the average cost for one day in the hospital. Home oxygen therapy is the most cost-effective and clinically effective treatment for those with COPD and low blood oxygen.

Conclusion

What does this mean to Palmer Home Medical Supply, rural hometown HME providers, and all other providers in a competitive bid area throughout America? I live in an area of the country with a large elderly population, and 43% of my clients are on Medicare. I truly fear what will happen to my customers and my small business when the competitive bidding storm thunders its way into rural America. I cannot survive if I can't serve Medicare beneficiaries, nor can I survive providing our current quality of product and level of service with a 26% cut in payment. Due to this competitive bidding storm, small businesses will be destroyed, and beneficiaries will be left to fend for themselves, threatening their current access to care and their quality of life.

I call on Congress to immediately delay the implementation of the competitive bidding program. As with any action that is taken to avert the train wreck that is competitive bidding, I ask that Congress include a repeal of the imposition of a 36-month cap on Medicare payments for home oxygen therapy. As a provider, I support the implementation of a rational alternative process to determine Medicare pricing for DME items and services.

I thank you for this opportunity to testify before the subcommittee and I welcome your questions.